

TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER

0 1 0 0 3

2. STATE:

Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

January 1, 2001

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

BIPA 3 702

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19B, Item 2b, Pages 1-2;
Item 2C, Pages 1-2

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 0
b. FFY 2002 \$ 09. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):Att. 4.19B, Item 2b, Pages 1-2;
Item 2C, Pages 1-2

10. SUBJECT OF AMENDMENT:

PPS for RHCs and FQHCs

11. GOVERNOR'S REVIEW (Check One):

- ☐
- GOVERNOR'S OFFICE REPORTED NO COMMENT
-
- ☐
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
-
- ☐
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Governor has waived review.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Robert J. Seiffert

13. TYPED NAME:

Robert J. Seiffert

14. TITLE:

Medicaid Administrator

15. DATE SUBMITTED:

March 23, 2001

16. RETURN TO:

HHS, F&S
Medicaid Division
Attn: Bob Seiffert
P.O. Box 95026
Lincoln, NE 68509-5026

FOR REGIONAL OFFICE USE ONLY

DATE RECEIVED

03/25/01

DATE APPROVED

JUN 22 2001

PLAN APPROVED - ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL

JAN 1 2001

TYPED NAME

ROBERT J. SEIFFERT

TITLE

MEDICAID ADMINISTRATOR

DATE SUBMITTED

MARCH 23, 2001

SIGNATURE OF REGIONAL OFFICIAL

[Signature]

DATE

JUN 22 2001

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

X The payment methodology for RHCs will conform to Section 702 of the BIPA 2000 legislation. (All States should check this one.)

 The payment methodology for RHCs will conform to the BIPA 2000 requirements Prospective Payment System.

X The payment methodology for RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology will:

- 1) be agreed to by the State and the center or clinic in a written memorandum form; and
- 2) will result in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

RURAL HEALTH CLINICS

A provider-based RHC is defined as an integral part of a hospital, nursing facility, or home health agency that is participating in Medicare and is licensed, governed, and supervised with departments of the facility.

PROSPECTIVE PAYMENT SYSTEM (PPS)

Effective January 1, 2001, the Prospective Payment System (PPS) base rate will be computed as follows:

1. Combine reasonable costs from the RHC center/clinic fiscal year 1999 and 2000 cost reports.
2. Divide the costs by the greater of: a) the total number of visits from the two fiscal year cost reports, or b) 12,600 visits (the required annual minimum visits times 2 years).

This PPS base rate will be the center's final rate for January 1, 2001 through September 30, 2001. Beginning October 1, 2001, the PPS base rate will be updated annually based on the Medicare economic index (MEI).

TN# MS-01-03

Supersedes

Approved

JUN 22 2001

Effective

JAN 01 2001

TN# MS-00-06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

ALTERNATIVE PAYMENT METHODOLOGY (APM)

For the rate period January 1, 2001, through September 30, 2001 centers/clinics may choose to have their rate computed under the Alternative Payment Methodology. To choose this method, the center/clinic must make this selection on the written memorandum form provided by the Department.

Under the Alternative Payment Method, the rate for Rural Health Clinic (RHC) services provided by provider-based RHCs associated with hospitals of 50 beds or less is the lower of cost or charges, as established by Medicare. Rates for the provider-based RHC centers/clinics associated with hospitals of 50 beds or more and Independent Rural Health Clinics are computed at the all inclusive encounter rate established by Medicare. The center/clinic's final rate for January 1, 2001 through September 30, 2001, is the greater of the APM rate or the PPS base rate. Beginning October 1, 2001, the PPS base rate will be updated annually based on the Medicare economic index (MEI).

For those non-RHC services for which no charge has been established by Medicare, NMAP makes payment according to Nebraska Medicaid practitioners fee schedule.

RATES FOR NEW RHC CENTERS/CLINICS

Effective January 1, 2001, initial interim rates for new RHCs entering the program after 1999, will be the average PPS rate of all RHC clinic/centers in Nebraska. The RHC's individual PPS base rate will be computed later, using its initial cost report. Once the PPS base rate has been established, it will be updated annually based on the Medicare economic index (MEI). The interim rate will be retroactively settled based on the RHC clinic/center's initial cost report.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

RHC MANAGED CARE PAYMENT

RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly State supplemental payments for the cost of furnishing such services, the difference between the payment the RHC receives from MCE(s) and the payments the RHC would have received under the alternative methodology. At the end of each RHC fiscal year, the total amount of supplemental and MCE payments received by the RHC will be reviewed against the amount that the actual number of visits provided under the RHCs contract with MCE(s) would have yielded under the alternative methodology. The RHC will be paid the difference between the amount calculated using the alternative methodology and the actual number of visits, and the total amount of the supplemental and MCE payments received by the RHC, if the alternative amount exceeds the total amount of supplemental and MCE payments. The RHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the RHC if the alternative method is less than the total amount of the supplemental and MCE payments.

Reimbursement for radiology services is included in the encounter rate.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

It is the responsibility of the centers/clinics to inform and supply the State of Nebraska with necessary documentation regarding changes to types of service, cost reports and any other documentation.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service. RHC core services provided via telehealth technologies are not covered under the encounter rate. See Attachment 3.1A, Item 2b.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The provider must be in compliance with the standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

X The payment methodology for FQHCs will conform to Section 702 of the BIPA 2000 legislation. (All States should check this one.)

 The payment methodology for FQHCs will conform to the BIPA 2000 requirements Prospective Payment System.

X The payment methodology for FQHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology will:

- 1) be agreed to by the State and the center or clinic; and
- 2) will results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

FEDERALLY-QUALIFIED HEALTH CENTERS

PROSPECTIVE PAYMENT SYSTEM (PPS)

Effective January 1, 2001, the Prospective Payment System (PPS) base rate will be computed as follows:

1. Combine reasonable costs from the FQHC center/clinic fiscal year 1999 and 2000 cost reports.
2. Divide the costs by the greater of: a) the total number of visits from the two fiscal year cost reports, or b) 12,600 visits (the required annual minimum visits times 2 years).

This PPS base rate will be the center's final rate for January 1, 2001 through September 30, 2001. Beginning October 1, 2001, the PPS base rate will be updated annually based on the Medicare economic index (MEI).

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